Has the WHO Global Code of Practice on the International Recruitment of Health Personnel been effective?

The adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel in May, 2010, ostensibly heralded a new era of accountability in the migration of health-care workers. Global health advocates lauded its unanimous adoption by all 193 WHO member states convening at the 63rd World Health Assembly as a sign of changing social expectations for human health resources, foreshadowing an imminent end to the brain drain of skilled health professionals from resource-constrained countries.

The effectiveness of the WHO Code to stem the brain drain from poor to rich countries is predicated on its voluntary implementation. However, the only study to evaluate the comprehensive implementation of the Code by all WHO member states has found disappointing results. WHO has often stressed that shortages and out-migrations of health-care workers are global in nature and will need global solidarity for a solution. Nonetheless, there are justifiable expectations that high-income countries whose primary care systems draw heavily from the low-income and middle-income countries should do more to limit such dependency. The USA is the leading destination of international medical graduates from sub-Saharan Africa and recruited into the US physician workforce. We found the records of 7370 graduates from medical schools in sub-Saharan Africa in the 2011 American Medical Association Physician Masterfile (AMAPM). After excluding all potential retirees, we estimated the number of potentially active graduates from sub-Saharan African medical schools in the 2011 AMAPM to be 7130. Although two-thirds of these doctors graduated from Nigerian and South African medical schools, the highest national proportion of national-to-USA physician émigrés were seen in Liberia (52%), Ghana (26%), and Ethiopia (20%). Because nearly all these migrant doctors were admitted into the US physician workforce before the inception of the Code, their numbers can serve as baseline metrics for future comparisons of physician migration from sub-Saharan Africa to the USA before and after the WHO Code.

3 years after adoption of the WHO Code, we revisited the AMAPM to ascertain whether the aggregate data for physicians from sub-Saharan Africa that we previously observed had changed. In the May, 2013, AMAPM, we found the records of 8260 graduates from sub-Saharan African medical schools, of whom 7900 (96%) were in active practice or were active but semiretired (working <20 h/week). These updated figures reflect a 10.8% (770) increase from the 2011 data, and an annual growth of 5.4% among graduates from sub-Saharan African medical schools appearing in the US physician workforce between mid-2011 and mid-2013. Our previous analysis suggested that migration of medical graduates from sub-Saharan Africa to the USA had increased by 38% between December, 2002, and mid-2011, reflecting an annual percentage growth of 4.5%.

The 2013 data reveal that the number of physicians from sub-Saharan Africa recruited into the US physician workforce continues to increase substantially despite the WHO Code adoption. We acknowledge that it is premature to dismiss the potential long-term effect of the WHO Code on the basis of the limited data reported above. Nonetheless, the increase in the annual growth rate of physicians migrating from sub-Saharan Africa to the USA in the AMAPM 3 years after the adoption of the WHO Code does not bode well for its promise to stem the physician brain drain from the region.

Moreover, the WHO Code might contain limitations of logic that undermine its effectiveness. The WHO Code does not define “international recruitment”, although the phrase appears 20 times in the seven-page document. Without explaining what it means by “active recruitment”, the WHO Code discourages the active recruitment of health personnel from countries with critical shortages (Article 5.1), but it reasserts freedoms of health-care workers “to migrate to countries that wish to admit and employ them” (Article 3.4). Thus, so long as the recruitment is “ethical”, another operative word begging for definition, high-income countries can recruit consenting doctors from resource-limited countries without obvious contravention of the WHO Code. Since high-income nations often deploy migrant health-care workers to serve their rural and medically underserved urban populations, the proimmigrant policy rationale is often based on addressing health disparities in the high-income country itself, an ironic justification for sapping the health-care talent of countries with low and middle incomes. That such recruitment practices of sub-Saharan African physicians into the US physician workforce are not at variance with the
recommendations of the WHO Code suggests that the 68th World Health Assembly in 2015 will not find the Code to have been either relevant or effective.

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